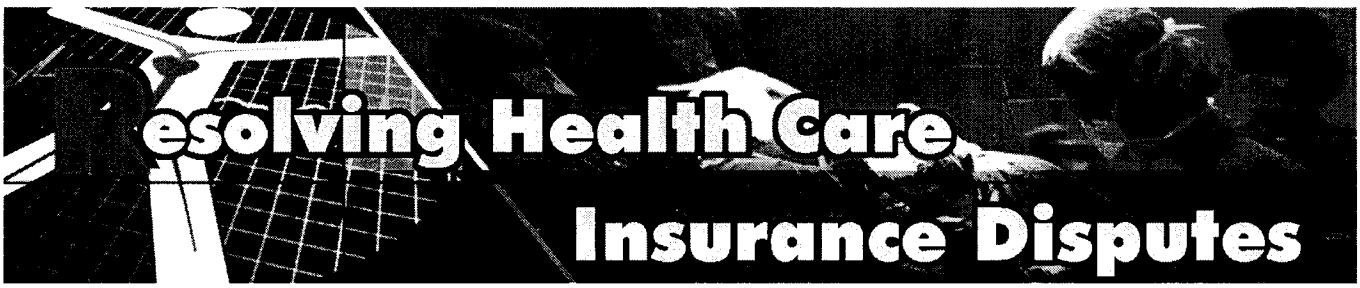


**Special Bulletin/September 1998**

*"As more and more Louisiana citizens realize the Department of Insurance can help them get their legitimate health care benefits paid, the number of health care complaints we receive continues to rise. The wealth of information in this health care bulletin will help you help us as we continue to strive to ensure that all Louisiana citizens get full payment of all health care benefits due them."*

**James H. "Jim" Brown**
**Commissioner of Insurance**

## RESOLVING HEALTH CARE INSURANCE DISPUTES

*This bulletin is being made available to assist you in choosing the right health care plan and resolving disputes about medical insurance claims.*

An estimated 1,900 health care complaints from Louisiana consumers will be handled by the Department of Insurance during 1998. That number is expected to increase to 2,000 in 1999. The continuing increase in complaints is due, in large part, to an increase in consumer awareness.

The growing number of complaints in Louisiana can be attributed at least in part to Insurance Commissioner Jim Brown's continued efforts to let Louisiana citizens know the Department's Consumer Services representatives are there to help them with their insurance problems.

Faced with increasing public demand for assistance in dealing with HMOs and health care insurers, the Louisiana Department of Insurance routinely goes to considerable lengths to help consumers dealing with health care claim denials, disputed claims, slow payments by health insurers and premium-related matters. A review of recent cases turned up the following examples of the Department of Insurance's success in safeguarding the interests of

Louisiana's health insurance consumers:

- The parents of a young, diabetic son thought they had chosen the group health plan option with the best coverage for insulin and diabetic supplies. Expecting to pay only a $10 co-payment in exchange for a 30-day supply of insulin and disposable supplies, they were dismayed to discover the plan only covered one unit of pre-packaged insulin per co-payment and only paid 50% of the cost of diabetic supplies. The parents filed allegations of misrepresentation with the Department of Insurance. Department consumer representatives informed the health plan that there were new laws requiring coverage of equipment, supplies and out-patient self-management training and education for the treatment of diabetes as with all other covered illnesses. Additional benefits were issued, and diabetics will now receive full coverage of their costs for treatment. This is an example of how many consumers benefited because the members of one family turned to the Department for help with their health care coverage.

- An elderly lady stepped in a hole and sprained her ankle. By the next morning she was in so much pain her blood pressure shot up to 220/124. She immediately went to the doctor for treatment of both conditions. The doctor, knowing her medical history and the problems he always had treating her hypertension, had her admitted to the hospital on the grounds that he feared she was about to have a stroke and that her ankle might be broken. The insurance company denied claims for the hospital stay, which made the lady's blood pressure rise again, and she sought help from the Department of Insurance.

  The company had denied the claims because they said the policy didn't cover losses due to hospitalization for diagnosis or routine examination. The insurance company's medical director had also concluded that confinement was not medically necessary. The Department of Insurance investigation found that the company had very broadly applied the policy limitations, and they should have paid the claim. As a result, the claims were reprocessed and full benefits paid. In addition, the company changed its claims handling procedures. Thanks to the successful intervention of the Department of Insurance, other people who are covered by this insurance plan will be spared the anxiety over payment of medical bills that this lady needlessly suffered.

The cases highlighted above reflect the variety of techniques that the Louisiana Insurance Department has developed in order to provide direct, one-on-one assistance to individuals with health insurance disputes. In each instance, many other people benefited because one person or family came forward to seek help from the Department.

The first contact the Department of Insurance has with most consumers who have health insurance problems is through the statewide, toll-free consumer hotline. In many instances, consumer affairs representatives can assist the caller based on the telephone conversation alone. In other instances, the caller will be asked to write a letter or complete a consumer complaint form to provide more detail.

## THE SCOPE OF STATE INSURANCE REGULATION

Many health care plans come under the direct regulatory control of the Louisiana Department of Insurance. With others, the situation is more complicated, but the Department can always be of help. The two types of regulatory control are as follows:

- ***State regulation.*** Many employer or employee groups purchase health insurance coverage from an insurance company. Others may purchase group health coverage from a health maintenance organization (HMO). Both are called fully insured health benefit plans. The Louisiana Department of Insurance regulates insurers of all such plans.

- ***Federal regulation.*** Some employer or employee groups, however, provide what are called self-funded health benefit plans. An employer or employee group may set aside funds and employee contributions each month to pay health coverage claims submitted to the plan. If the plan is self-funded and offered by a private sector employer or bona fide union, the designated regulatory authority is the U.S. Department of Labor's Pension and Welfare Benefits Administration.

The Louisiana Department of Insurance is here to serve all Louisiana consumers. Therefore, it accepts all complaints. If a self-funded plan is involved, a Department representative works with the administrator of the plan in order to try to resolve the claims dispute.

On average, 14% of health care complaints received and handled by the Department involve self-funded plans.

## UNDERSTANDING TYPES OF HEALTH INSURANCE

Each year, fewer and fewer Americans are covered under traditional **fee-for-service** health insurance plans, which allow insured individuals to go to a doctor of their choice and then submit health insurance claims for payment. Instead, an increasing number of Louisiana citizens now are covered by one of the following arrangements:

- **Managed Care Organization** (MCO). Only a Health Maintenance Organization (HMO) is specifically licensed to provide all covered health services through a network of doctors, hospitals, laboratories, etc. The health care providers are usually under contract with the HMO but occasionally may be HMO employees. HMO plans pay providers under a contract arrangement that may be a monthly set amount (a capitation fee) regardless of the amount of services performed, or based on the services actually provided. When you enroll in an HMO, you choose one of the doctors as your primary care physician (PCP) to manage all of your health care. Whenever you need health care, you first consult your primary care physician. Your PCP may refer you to an HMO-approved specialist. Some self-funded employer plans provide benefits through their own MCO that is not required to meet the HMO standards. Also, some insurance plans now offer MCO coverage options in addition to traditional fee-for-service coverage.

- **Preferred Provider Organization** (PPO). A PPO is a group of doctors, hospitals and other health care providers (preferred providers) who have agreed to provide services to members of a health plan for discounted fees. Some employers combine the PPO with a traditional major medical plan to allow you to use providers who are not on the PPOs' preferred list. But to encourage you to use a provider who is on the PPO list, you will usually have lower out-of-pocket expenses than if you use a provider who is not on the list.

- **Point-of-Service Plans**. These plans are essentially HMOs that allow members to use services provided outside of the network without prior approval from a network doctor. Point-of-service plans offer lower deductibles and no coinsurance for visits to doctors *inside* the network. Visits *outside* the network normally require the payment of deductibles and coinsurance the same as a standard insurance policy.

## CHECKING OUT A HEALTH INSURANCE PROVIDER

Before you buy health coverage, find out about the company selling the plan. Here are factors to consider:

- **Customer Service.** Find out how the company services its policyholders. For example, does the company have a toll-free customer service number?

- **Complaint History.** Call the Department of Insurance and ask whether the company had an unusually high number of consumer complaints.

- **Licensing Status.** Also ask the Department if the insurance company is licensed to do business in Louisiana.

- **Cost.** Premiums for health insurance will vary greatly because there are no standard plans. When you look at bids from several companies, you will also need to look carefully at the benefits offered. Also, keep in mind that the actual cost for your health coverage will be determined after you submit information about your health.

- **Financial Stability.** Financial stability helps ensure that a company can pay its claims. The Department of Insurance establishes requirements that each company must follow and continually monitors the financial stability of insurance companies operating in the state. Independent organizations also rate the financial stability of insurance companies. When you call the Department of Insurance to check out the company, ask how it is rated. Remember these ratings are opinions only and do not guarantee that a company is financially sound. Your public library or the Internet may also have published ratings on health insurance carriers.

## QUESTIONS TO ASK WHEN SHOPPING FOR HEALTH CARE

### About Coverage

- What does the plan pay for?
- What does the plan not pay for; that is, what does it specifically exclude?
- What are the limits on pre-existing medical conditions?
- Will the plan pay for preventive care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, durable medical equipment.
- Will the plan pay for prescriptions?
- Does the plan have mental health benefits? If so, do they differ from the coverage for other illnesses?
- Will the plan pay for long term physical therapy?

### About Premiums

- Do rates increase as you age?
- How often can rates be changed?
- How much do you have to pay when you receive health care services (co-payments and deductibles)?
- Are there any limits on how much you must pay for the health care services you receive (out-of-pocket maximums)?
- Are there any limits on the number of times you may receive a service (lifetime maximums or annual benefit caps)?

### About Customer Service

- Has the company had an unusually high number of consumer complaints?
- What happens when you call the company's consumer complaint number?
- How long does it take to reach a real person?

## HOW TO MAKE A HEALTH INSURANCE CLAIM OR DISPUTE A CLAIM DENIAL

### Things to do *before* you file a claim:

- Review your policy or employee booklet carefully to be sure the service in question is covered.
- Follow any managed care rules, including pre-certification requirements and use of network providers.
- Give claim forms to the provider, with your policy number and other identifying information.

### How to submit your claim properly:

- Find out if your provider submits the claim for you or if you need to do it.
- If you need to do it, review the information to be sure it is complete and correct.
- File the claim as soon as you get the bill from the provider.
- Send the claim to the right address.
- Keep a copy of everything you sent and the date you sent it for your records.

**Allow reasonable time for company to process your claim**. The company will inform you if it needs any additional information to complete the claim. Sometimes, the company will request additional information directly from the providers or will return the claim form to you for more information. After the company has all the information it needs, it has a certain length of time, normally 30 days, to process your claim. The company must send you an explanation of benefits that explains why it paid, what it paid and why it didn't pay what it didn't.

## If your claim is paid:

- If you assigned benefits to the provider, the benefit check will be sent directly to the provider.
- You will pay any deductibles and co-insurance.
- If you did not assign the benefits, the check will come to you, and you will need to pay your providers for the entire amount.

## If your claim is denied:

- The reason for denial should be stated on the explanation of benefits you received when you were first covered by the plan.
- If you disagree with the reason given for denying the claim, check your policy or employee booklet for the company's appeal procedures.
- The company should be able to answer procedural questions about appeals over the phone.
- Your appeal should be in writing and may require information from your doctor.

## Filing a consumer complaint:

If you've tried unsuccessfully to resolve a claim problem with your company or agent, call or write us here at the Department of Insurance. Very often, companies will resolve disputes after the Department intervenes on a consumer's behalf. If it becomes necessary to file a written complaint with the Department of Insurance, ask for a complaint form or write a letter, being sure to include the following information to speed processing of your inquiry:

- Include your name, address, and daytime phone number.
- State your case briefly, giving full explanation of the problem and what type of insurance is involved. Include the name of your insurance company, policy number, and the name of the agent or adjuster involved.
- Supply any documentation you have to support your case including phone notes.
- State what has been done to resolve your problem including whom you have talked to and what you were told.
- For future reference, keep a copy of your letter and any other information you submit to the Department with your claim.

When you contact the Department, a consumer affairs representative will review your complaint and advise you on whether you have sufficient grounds to believe it is worth your while to dispute the claim. If you decide you still want to pursue the matter, the Department will investigate your complaint and keep you advised of what has happened. If a company

insists your complaint or claim is not valid, the Department cannot require the company to make payment unless a state insurance law has been violated or the company is not adhering to the insurance contract. In some cases, legal action is the only way to resolve health insurance disputes. You may want to consult a lawyer if your complaint cannot be resolved, especially if a significant amount of money is at stake.

*Anyone with insurance-related questions or concerns is invited to contact the Louisiana Department of Insurance at 1-800-259-5300 or 504-342-0895 in Baton Rouge or write Department of Insurance, P.O. Box 94214, Baton Rouge, LA 70804-9214. Our internet address is http://wwwldi.ldi.state.la.us and our email address is public@ldi.state.la.us .*